96CV06251-EHN-MD

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

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EVANGELOS DIAKIDIS,

Petitioner,

- against -

JOHN J. CALLAHAN, Acting Commissioner of Social Security,

Defendant.

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CV 96-6251

MEMORANDUM AND ORDER

JUDITH MITCHELL, ESQ.
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Sag Harbor, New York 11963
for petitioner

ZACHARY W. CARTER
UNITED STATES ATTORNEY
(Nancy A. Miller, of counsel)
One Pierrepont Plaza
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for defendant

NICKERSON, District Judge:

Petitioner brought this proceeding under 42 U.S.C. § 405(g) to review a final decision of the Acting Commissioner of Social Security that plaintiff was not disabled and not entitled to disability insurance benefits (benefits) under the Social Security Act.

C/M

I

Plaintiff was thirty-three years old on December 31, 1991, the date he was last insured. He claimed that on October 8, 1989 he became disabled due to a back condition and depression. The question before the Commissioner was whether plaintiff was disabled within the meaning of the act between the dates October 8, 1989 and December 31, 1991.

Plaintiff applied for benefits under date of August 4, 1994. In his disability report dated September 24, 1994, plaintiff said, among other things, that he could not lift "certain weight," could not bend "a lot" without pain, and could not walk "for long distances, meaning a mile or more." After the application was denied after reconsideration, plaintiff applied on July 6, 1995, for a hearing before an Administrative Law Judge who held the hearing on March 18, 1996. The Administrative Law Judge determined that plaintiff was not disabled at any time through the date he was last insured, December 31, 1991.

The Administrative Law Judge made the following findings. Plaintiff has not worked since September 8, 1989. The medical evidence establishes that he has levoscoliosis and mild degenerative changes of the facet joints but that these impairments are not "sufficiently severe" to meet or equal the requirements of any impairment "listed" in the regulations. His allegations of pain and other symptoms precluding all work are not credible, not supported by objective medical evidence for the relevant period, and inconsistent with his admissions as to his activities and functional capacity. His allegation of depression is not supported by any evidence contemporaneous with the date last insured. He cannot do his past relevant work as a baggage handler, short order cook, bus boy, or waiter, but has the residual functional capacity through December 31, 1991 to do at least sedentary work. Jobs that he was capable of doing during the relevant period existed in significant numbers in the regional and national economy.

II

The record shows that plaintiff hurt his back while lifting baggage on October 7, 1989. On October 18, 1989 he began seeing Dr. Theodore Giannaris, an orthopedic surgeon and the treating physician. On March 14, 1990, a CT scan of plaintiff's lumbosacral spine revealed no abnormality. The radiologist, Dr. Morton Jaffe, reported that the scan showed no evidence of disc herniation, bulging annulus, or spinal stenosis, that the apophyseal joints appeared normal, and that there was no bony or soft tissue encroachment on the spinal canal or neural canal.

The record contains twenty-two reports on the New York State Workers' Compensation Board form made by Dr. Giannaris, covering the period from October 18, 1989 through March 1992. Over that entire period the nature of the injury was recorded as sprain of the lumbar spine.

The reports almost always described plaintiff's condition to include back pain and stiffness or weakness. Sometimes they reported

spasticity and straight leg raising positive. The treatment rendered was generally described as heat, rest, analgesics, and occasionally exercises. By March 3, 1991 the doctor noted the addition of a corset and sent plaintiff for physical therapy. By July 31, 1991, the description of treatment again noted only medication, rest, and heat. On November 15, 1991 the doctor described the treatment as heat, corset, and analgesics. On January 17, 1992, the treatment entry was medication, heat, avoid bending and lifting, and "vocational rehabilitation recommended." A similar entry was made for March 11, 1992.

At various times the doctor reported improvement in the back symptoms, for example, on April 11, 1990, May 25, 1990, May 22, 1991 and March 11, 1992. At other times the reports noted episodes of severe pain, for example on August 29, 1990 and January 17, 1992. But for the most part the doctor reported that the pain was much the same throughout the period. In some early reports

the doctor noted "no radicular symptoms" and "no neurovascular symptoms," but thereafter he made no reference to these matters.

On March 24, 1992 Dr. Giannaris testified in a Workers' Compensation Board hearing as to his treatment and findings with respect to plaintiff. He said that there was improvement in plaintiff's condition and that from September 1990 on he was "partially disabled." By that term the doctor said he meant that plaintiff "can perform some duty, but he cannot lift, bend or push heavy objects." The doctor testified that as of the date of the hearing plaintiff still had pain radiating to the right leg and tenderness in the lumbosacral area with limitation of forward motion and inability to bend over to put his shoes on. Dr. Giannaris concluded that while plaintiff could not work at his past job he would be able to perform "light duty" work.

After some unidentified date in 1992 plaintiff ceased going to Dr. Giannaris for treatment until 1994. On August 31, 1992,

plaintiff began seeing Dr. Richard J. Radna, a neurosurgeon. That doctor's first report to National Union Fire Insurance Co. stated that he found a moderate paravertebral spasm in the lumbosacral region with a moderately diminished range of motion, secondary to pain. Straight leg raising and the Patrick test were moderately restricted. The neurological examination was unremarkable. Dr. Radna's impression was lumbosacral, musculoskeletal, and radicular pain syndrome.

On October 21, 1992, Dr. Radna's report recorded unchanged clinical findings. The doctor evidently had reviewed the CT scan of the lumbosacral spine taken on March 14, 1990. Contrary to the radiologist's opinion that the scan showed no abnormality, Dr. Radna said that the scan showed a discogenic and osseous lateral recess stenosis at the L3/4 and L4/5 levels. He recommended decompressive micro-laminectomy and medical facetectomy and requested the insurance carrier's authorization.

From November 23, 1992, through November 30, 1994, Dr. Radna saw plaintiff from once a month to once every four months. His clinical findings in reports to National Union Fire Insurance Co. never changed throughout the two year period. In each report he continued to request authorization for the surgery recommended on October 21, 1992. On July 25, 1994, Dr. Radna's report stated that due to a severe exacerbation the surgery would be performed under alternate insurance, pending carrier authorization.

By September 22, 1994 plaintiff was seeing Dr. Giannaris once again. In a report to the New York State Office of Disability Determinations dated November 10, 1994, Dr. Giannaris made the same diagnosis as he had in 1992. Plaintiff was obese, wore a back support, and had much the same symptoms as in the past, pain in the lower back with stiffness and weakness, inability to sit or stand long, inability to bend or lift and pain radiating to both buttocks and right leg with numbness. The doctor said he was treating

plaintiff with analgesics, muscle relaxers, and physiotherapy with partial improvement.

Dr. Giannaris did not report any significant abnormality in gait. The clinical findings were tenderness of the back, spasm, limited motion, forward flexion to 60 degrees, lateral bending to ten degrees out of thirty with pain, straight leg raising limited on both sides, and one inch atrophy of right lower thigh. In response to the question whether plaintiff had displayed any behavior suggestive of a significant psychiatric disorder the answer was "normal."

With respect to plaintiff's functional capacity Dr. Giannaris filled in a form with entries stating plaintiff could lift and carry five pounds, sit less than six hours a day, stand and/or walk two hours a day, and postural limitations.

A consulting physician, Dr. D. Karam, made a report of his orthopedic examination of plaintiff on December 28, 1994. He found no atrophy and excellent coordination and control of the lower

extremities, with no diffuse sensory impairment to pinprick. Plaintiff walked without a cane, got up from a chair with slight difficulty and from the table to a sitting position with difficulty. He got up on his heels and toes with some difficulty.

In the lumbosacral spine Dr. Karam measured the flexion from vertical to seventy degrees, lateral flexion and rotation to forty degrees right and left, and straight leg raising sixty degrees to right and left. There was pain on motion of the back in all directions but no spasm on palpation. The range of motion of the knees was normal and without pain.

The doctor's impression was low back derangement. The ability to lift, carry, push and pull heavy objects was limited by low back pain. The doctor's prognosis was fair. X-ray findings of a radiologist accompanied Dr. Karam's report and stated that there was levoscoliosis and mild degenerative changes of the facet joints, but no compression deformities or paraspinal masses. The disc spaces were well maintained.

III

On January 3, 1995, Dr. Radna testified at a Workers' Compensation Board hearing. He repeated his disagreement with the conclusions of the radiologist who reported his findings as to the CT scan of March 14, 1990. Dr. Radna reiterated his views stated in his October 21, 1992 report to National Union Fire Insurance Co. that plaintiff required surgery, which he said was planned for early 1995.

At the hearing Dr. Radna was asked why, if plaintiff had had a "severe exacerbation," as the doctor claimed in his July 25, 1994 report, he had delayed surgery for more than six months. Dr. Radna responded that he had "recommended an aggressive weight-loss program which would help [plaintiff] preoperatively" and plaintiff "had to manage some personal affairs of his life" before surgery. There is nothing in the record to show that the surgery recommended by Dr. Radna was ever authorized or performed.

For the second time Dr. Giannaris testified at a Workers' Compensation Board hearing, this one on December 6, 1995. He stated that after 1992 he did not see plaintiff again until September 1994, that at that time plaintiff's condition had not changed appreciably, and that he was totally disabled for "the type of work he was doing" involving "lifting heavy objects and carrying things," but that he could do some work so that the doctor had recommended vocational rehabilitation.

The record does show from reports submitted by plaintiff's attorney to the Appeals Council that no surgery had been performed as late as September 25, 1996. Plaintiff submitted to the Appeals Council a report dated July 16, 1996, to National Union Fire Insurance Co. made by Dr. N. Sundaresan. This doctor stated that plaintiff had moderate spasm with limitation of movement, that plaintiff was overweight, that straight leg raising tests were restricted bilaterally, and that deep tendon reflexes were normal. The report

also stated that the CT scan of 1990 showed plaintiff had a bulging disc at L4/5, that weight loss should be considered, and that a more recent MRI scan should be taken.

On August 21, 1996 Dr. Folco Scappatici performed an MRI examination. That doctor reported that the MRI showed no evidence of disc herniation or spinal stenosis, but only a broad mild annular bulge at L4/5 with no mass effect on the thecal sac. The remainder of the test was negative. Dr. Scappatici also read the old March 14, 1990 CT scan and read it to show evidence of lateral recess stenosis at L3/4 and L4/5, a matter on which the doctor stated he could not comment, adding that a repeat CT scan might be more helpful.

Dr. Radna reviewed the MRI and in a report dated September 25, 1996 to National Union Fire Insurance Co. read it differently than did Dr. Scappatici. To Dr. Radna the MRI was "significant for a multi-level discogenic and osseous lateral recess stenosis." He once again recommended

surgery and requested carrier authorization. Apparently he had not received authorization to have the surgery performed under "alternate insurance" as he had asked in his report of July 25, 1994, referred to above.

IV

Plaintiff also offered evidence as to his mental condition. On January 13, 1995, Dr. Francine San Giovanni filed a report with the New York Office of Disability Determinations stating that she had been seeing plaintiff since August 1993, more than one and a half years after the date plaintiff was last insured. Dr. San Giovanni diagnosed plaintiff as having a major depression, chronic and recurrent, and dysthymia. She treated him with Prozac and Elavil to help him sleep.

Dr. San Giovanni testified at a hearing for the Workers' Compensation Board on August 11, 1994. She said that in August 1993 plaintiff spent most of his time in his room looking at television and was not motivated to participate in

any activities. The doctor felt that back pain was a major stress which produced depression. She said that he was totally disabled. Every three months or so he went into a more intense stage of depression which might last for about two months and than have one month where he had a lower level of depression. The doctor was not clear when the onset of what she called the base line depression or the major depression began.

On December 22, 1994, Dr. R. Ravid, a consulting psychiatrist, examined plaintiff. The doctor said that plaintiff related well to the interview, smiled at appropriate times, and walked slowly and hesitantly. His speech though accented was goal directed, fluent, and relevant, and at a normal rate and rhythm. Plaintiff reported he felt depressed although he was then sleeping due to his taking medication. He said he felt useless because he was not working. He denied being homicidal or suicidal, denied experiencing hallucinations, and had no feelings of persecution or being subjected to thought control.

Doctor Ravid reported that plaintiff was alert and oriented, was able to perform some simple calculations, and had knowledge of public figures. His vocabulary and sentence structure were consistent with average intelligence. He appeared able to understand, remember, and carry out instruction, and to relate hypothetically to supervisors and co-workers, based on his ability to relate to the doctor. His capacity to withstand work pressure appeared to be fair.

The doctors's diagnosis was dysthymia, and history of alcohol abuse. She said he might benefit from a trial of a different antidepressant and was likely to function at the same level as now in the near future. The prognosis was fair.

V

Plaintiff also submitted evidence to this court after the action was brought. He offered a report from Dr. Giannaris dated January 7, 1997. The report is in the form of answers to a questionnaire, presumably prepared by plaintiff's

lawyer or representative. The most critical question reads "Have the reports of Drs. Scappatici, Sundareasan (sic), and Radna changed your mind regarding your diagnosis, prognosis for your patient as of 12/31/91?" Dr. Giannaris checked "yes." In the answer to the question "If Yes, how so/ why so?" To this Dr. Giannaris stated "His condition is more serious than my impression." He also checked "yes" to the question of whether plaintiff's condition as of December 31, 1991, met or equaled a listing in the regulation.

Under 42 U.S.C. § 405(g) this court may "order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding."

In order to succeed in obtaining a remand for the taking of additional evidence plaintiff must show that the proffered evidence is new and not

merely cumulative of what is already in the record and is material, that is, both relevant to plaintiff's condition during the period for which benefits were denied and probative. See Lisa v. Secretary, 940 F.2d 40, 42 (2d Cir. 1991). To be material there must be a reasonable possibility that the new evidence would influence the Commissioner to decide plaintiff's application differently. Id. Finally, plaintiff must show good cause for the failure to present the evidence earlier. Id. at 42-43. See also Perez v. Chater, 77 F.3d 41, 45 (2d Cir. 1996).

Plaintiff has not met these prerequisites. The only truly new thing in Dr. Giannaris' related report is that he has changed his mind. Moreover, the doctor's new findings are hardly relevant to plaintiff's condition on or before December 31, 1991. Finally there is no good cause for plaintiff's failure to have submitted the report earlier. As shown above the doctor had submitted reports prior to the date of the Administrative Law Judge's decision and had testified at two

Workers' Compensation Board hearings on behalf of plaintiff. The recent Dr. Giannaris opinion is based basically on Dr. Radna's reports, and those reports were made as early as August 1992.

VI

When a claimant's condition becomes disabling only after the expiration of his insured status, he is not entitled to a period of disability insurance benefits even if the impairment existed prior to the date last insured. Arnone v. Bowen, 882 F.2d 34, 37-38 (2d Cir. 1989). In this case to obtain benefits he must have been disabled before December 31, 1991.

There was substantial evidence to support the decision of the Administrative Law Judge that plaintiff was not disabled by a back impairment from August 1989 through December 31, 1991. A radiologist took a CT scan on March 14, 1990. He reported that the scan showed no abnormality.

The Administrative Law Judge could credit the radiologist's opinion over that of Dr. Radna

claiming that the scan reveals stenosis at the L3/4 and L4/5 levels. Throughout his treatment Dr. Radna made only negative neurological findings. Dr. Giannaris, the treating physician, diagnosed only a back sprain through December 31, 1991. He found no significant neurological or vascular deficit. He did not report any reflex deficits or gait abnormality.

Even after December 31, 1991 there were no positive neurological findings. Dr. Radna, who first treated plaintiff over six months after that date, found that plaintiff's "mental status, cranial nerves, motor, sensory, reflex, cerebellar, gait, and Romberg examinations [were] unremarkable."

The consulting doctor, D. Karam, an orthopedist, found three years after December 31, 1991 that plaintiff had no muscle atrophy, no spasm on palpation, muscle strength for the most part normal, knee and ankle jerks present and equal, excellent coordination and control of both lower extremities, and no diffuse sensory

impairment to pinprick. The X-ray performed as part of the consultative examination showed only levoscoliosis and mild degenerative changes and disc spaces well maintained. The X-ray revealed no compression deformities.

Dr. Giannaris's testimony at the Workers' Compensation Hearing in March 1992, supported the decision that plaintiff could perform sedentary work. Dr. Giannaris testified that after September 1990, less than twelve months after plaintiff claimed disability, plaintiff was partially disabled, meaning he could do work that did not include lifting, bending or pushing heavy objects. Indeed the doctor testified plaintiff could do "light work."

The Administrative Law Judge was entitled to give greater weight to the more contemporaneous opinions of Dr. Giannaris rather than those the doctor voiced years after December 31, 1991.

The reports submitted to the Appeals Council were based on examinations made in 1996, five years after the critical date of December 31,

1991. Moreover, Dr. Sundaresan's opinion was that the 1990 CT scan revealed only a bulging disc at L4/5. The August 1996 MRI report seemingly supported the decision of the Administrative Law Judge that plaintiff was not disabled, because it showed no evidence of disc herniation or spinal stenosis, and described the disc bulge at L4/5 as being only "mild" and as not impinging on the thecal sac.

There is no basis for reversing the decision of the Commissioner as to plaintiff's mental condition before December 31, 1991. Dr. Giannaris reported that plaintiff did not behave in such a way as to indicate a psychiatric condition. The reports of Dr. San Giovanni did not bear on plaintiff's condition in 1991.

The court concludes that there is substantial evidence showing that plaintiff's alleged impairments did not prevent him from engaging in substantial gainful activity on or before the date last insured.

The Commissioner's decision is affirmed.

So ordered.

Dated: Brooklyn, New York
October 30, 1998

Eugene H. Nickerson

Eugene H. Nickerson, U.S.D.J.